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Sociology and Human Sexuality

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Sociology and Human Sexuality

Abstract

Greater toleration of premarital and extramarital coitus and the increased emphasis on sexual gratification in marriage are not novel trends in American society, but the pace of change today probably is unprecedented. There is intense public discussion of what were once exclusively personal matters. Practices that a generation ago were considered socially deviant, such as cohabitation or homosexuality, are tolerated, if not accepted.

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Sociology and Human Sexuality

L. Reiss, Ph.D., and Frank F. Furstenberg, Jr., Ph.D.

Greater toleration of premarital and extramarital coitus and the increased emphasis on sexual gratification in marriage are not novel trends in American society, but the pace of change today probably is unprecedented. There is intense public discussion of what were once exclusively personal matters. Practices that a generation ago were considered socially deviant, such as cohabitation or homosexuality, are tolerated, if not accepted.

The very changes that invite choices also create new responsibilities. The coexistence of "old" and "new" moralities bewilders many people, including the young. Some parents are no longer sure of their own standards, much less what to teach their children. Young people, in turn, are no longer sure of what to do or from whom to get advice.

Amid this confusion, physicians are called upon to provide special knowledge. They often may find themselves in the uncomfortable position of being social arbiters to interpret changing sexual standards. In doing so, they have to venture outside the familiar confines of the traditional medical role and seek information on values and behavior in various segments of society, some far removed from their own. Most cannot be experts in the social, as well as the biological and physical sciences, but they can find in the sociological view of sex much that bears on patient care.

Until rather recently, most sociologists have avoided systematically studying sexual behavior. Since Alfred Kinsey's pioneering studies of sexual behavior appeared some 30 years ago, there has been less reluctance to study sexual behavior, and in the past decade many nationwide studies¹⁻³ and polls⁴⁻⁶ have appeared. Although some of these do not bear the weight sometimes placed on them, they have spurred public discussion of such formerly taboo topics as marital and nonmarital sexual relationships, sexual function and dysfunction, orgasm, contraception, abortion, sexually transmitted disease and cohabitation. In fact, the sheer amount of information, some of it based on questionable data sources, presents a challenge to the physician who is called upon to respond to a variety of questions about sexual matters.

PREMARITAL SEXUAL BEHAVIOR

Historical and Cross-Cultural Evidence. Studying a society's sexual behavior and attitudes at one point in time is as limited as looking at a patient's medical condition on one specific day. Accordingly, it makes sense to collect

data over an extended period but, in doing so, one must avoid historical clichés. Societies, like people, embellish the past and develop mythologies about it. For instance, some observers talk of a time when premarital virginity prevailed for both sexes, but parish registers as far back as the 16th century reveal that illegitimacy was common in England and many parts of Europe. Even where people disapproved of premarital coitus, babies were born out of wedlock or couples married in haste.^{7,8} The records of one Massachusetts church show that 200 years ago one-third of all women married there had confessed fornication to their minister. (Without the confessions, their babies would not have been baptized.) There were doubtless other nonvirgins who, not being pregnant, did not confess. We are not saying that premarital coitus was always as prevalent as it is today, but even 200 years ago we were not essentially a nation of virgins at marriage.⁹

Although premarital coitus was officially condemned strongly in most parts of this country, it was informally condoned by many people as long as a resulting pregnancy led to marriage. Community pressure was sufficient to keep the majority of premarital pregnancies from leading to out-of-wedlock childbirths.¹⁰

Anthropological evidence shows that American society, seen in a cross-cultural perspective, has been rather restrictive about premarital coitus.¹¹ Many societies, especially nonliterate ones, give young people more latitude for sexual experimentation after or even before puberty.¹² Nevertheless, few if any cultures have approved of socially "unlicensed" childbearing. Virtually all cultures have some form of marriage rules, at least in part to assign parental rights and responsibilities.¹³ It might be said that society tries to regulate sexuality partly in order to regulate parenthood. Modern contraception, allowing a greater separation of sexuality from reproduction, has probably lessened the importance placed on premarital chastity.

Current Behavior. In our society, as in virtually all others,¹⁴ different values have been placed on virginity for men and for women. Men have been tacitly encouraged to violate public standards, women to maintain them. Some early sociological studies of sexual behavior chronicle the struggle between males and females over sexual "license" or "virtue."¹⁵⁻¹⁹

Recent estimates show that the trend toward greater acceptance of premarital coitus, noted by Kinsey et al in the 1940's, has accelerated since then.^{3,20,21} Kinsey found that a rise in the incidence of premarital coitus had begun during the 1920's and had continued at a slow rate in subsequent decades. There is now little doubt that another relatively great shift toward earlier coital experience occurred in the late 1960's and early 1970's. As in the previous era, the changes were more evident among females than males.^{1,22}

Some of the most carefully collected data on the sexual behavior of teenage females^{20,21} reveal that in 1979 nearly two-thirds of all white women were nonvirgins by age 19. Blacks had a higher incidence of premarital coitus than whites, began coitus earlier and hence were far more vulnerable to pregnancy. Men tended, as in the past, to start coitus earlier than women and to have more frequent and varied experiences. The great majority of men are nonvirgins by their late teens.^{3,23,24}

Nonmarital coitus during adolescence is not considered as socially deviant as it was a decade or so ago. Adolescents, however, are not invariably prepared for the concomitants of coitus, as the high rates of teenage pregnancy and sexually transmitted disease show. Critics of the liberalization of sexual standards have sometimes argued that the diminished importance placed on premarital chastity can be traced to the availability of modern methods of birth control, in particular oral contraceptives. In 1976, however, 16 years after the pill became available, most sexually active teenagers had never used oral contraceptives regularly, if at all. It seems unlikely that the advent of the pill or other modern methods of birth control produced the "sexual revolution." As yet, there is no evidence to show that availability of family planning services alters the incidence of premarital coitus in any predictable way,^{21,22} although it does seem to aid in containing the risk of pregnancy.^{21,25}

Before Kinsey's studies, there was some interest in, but little data about, the sexual practices of people from different social strata or with varying lifestyles. Kinsey et al found that sexual behavior varies by education, occupational level and income—for instance, that the middle and upper classes begin coitus later than the lower classes and are more likely during adolescence to engage in masturbation and petting as alternatives to coitus. More recent surveys^{1,21} have found a narrowing of class differences in both sexual behavior and attitudes about sexual practices.

Today the incidence of coitus among adolescent females does not vary much by social class, but there are some differences in the use of contraception and abortion.²¹ Lower-class women are more likely to bear children out of wedlock, at least in part because contraception and abortion are less accessible to them and perhaps also less acceptable.²⁶

Age also has a powerful influence on sexual values and behavior. Virtually all recent studies show that the young have a more permissive view of premarital coitus than their elders.²⁷ There are two possible sets of reasons that adults appear to be more conservative. One is that young people are more responsive to changing mores and/or that the risks of pregnancy and STDs do not seem as great to them. Furthermore, the youth culture and its courtship systems promote more permissive standards. The second reason is that parents' social responsibility for their children's behavior makes them less sexually permissive. They often feel they must take the blame if their teenager becomes pregnant or contracts a STD.

To learn which of these two factors was more important,¹ permissiveness was compared among different age groups: among people the same age in differing family situations and, within the adult group, among those who did and did not have teenage children.¹ There were consistent differences by age; however, among the adults, there was considerably more variation between parents and nonparents of the same age. Being in the parental role appears to lower the permissiveness even of adults who accept a great deal of experimentation in their own marital or extramarital lives.

The differences between the values of parent and child often limit communication between them. Adolescents, perceiving parental disapproval, seek information and advice from their peers, thus displacing the parents in sexual

socialization. Expecting to have little influence, the parents often abdicate responsibility for providing sexual education in the first place.

In a study of pregnant adolescents and their parents, it was reported that parents were genuinely shocked to discover that their daughters were pregnant, even when they knew that most adolescents in their neighborhood were sexually active.²⁸ Interviews with the daughters confirmed that they had usually kept their sexual activity secret from their parents. The daughters were inclined to view sex as "something that just happens," leaving to chance whether they became pregnant.²⁹ The girls who had made their sexual activity known to their parents were far more likely to use contraception and less likely to become pregnant in early adolescence.

With or without parental awareness, the most autonomous youth are more successful at contraception.³⁰ It seems that if adolescents are well informed and are taught to act independently, they will take steps to avoid unwanted pregnancy—if, of course, they have access to contraceptives, which many do not. Thus, it would seem that the family physician may have a role to play in imparting sexual information to both adolescents and their parents. When indicated, the physician may also assume responsibility for referring the adolescent to a family planning clinic for counseling or contraceptive instruction.

As an aside, it is also worth pointing out that the trend toward nonmarital sexuality, although most visible among the young, has apparently increased in all age groups. A sizable proportion of adults in their middle years live outside marriage, at least for a while, after divorce or a spouse's death.³¹ They participate in nonmarital sexuality as do their children, and fewer conceal behavior that years ago they might well have carried out surreptitiously. Many people over 65 also cohabit, some to avoid losing Social Security and other pension benefits, but others simply because they can accept sexuality outside marriage. Physicians should no longer expect older persons who are not married to be sexually inactive.

Consequences. Young people are exposed to complex messages about sex, ranging from explicit encouragement to active discouragement. Although values and guilt may affect the likelihood of sexual behavior, once coitus occurs, guilt does not usually terminate that conduct. Rather, those who feel guilty typically repeat the behavior despite that feeling.¹ Guilt about violating social codes may be less common and acute today with the erosion of commitment to premarital chastity in society at large. However, more than one-third of female nonvirgins felt guilty about their first act of coitus.²³

Some subcultures still prize virginity highly; young people in these subcultures who want to remain virgins may feel intense conflict over maintaining a standard no longer adhered to by those outside their subculture. On the other hand, as permissive attitudes become more widespread, shame or anxiety over *not* losing one's virginity may increase. Young people may feel ashamed or abnormal if they have not experienced coitus by late adolescence.

Because of the recent relaxation of laws that once virtually denied contraceptives to minors, contraceptive use by adolescents is increasing but is still very irregular.²¹ Even college students frequently do not practice birth control

at all or regularly.³² It has been found that over one-quarter of nonvirginal teenage women never used contraception; only 30 per cent always did so.²¹

Ignorance is still a major reason for the young not using contraception.^{33,34} Only about 40 per cent of teenage women know when during the menstrual cycle the risk of pregnancy is highest.²¹ Many adolescents do not know how or where to obtain contraceptives, which methods to use, or which social agencies offer contraceptive assistance. Moreover, contraception is used less regularly and effectively by those whose sexual behavior is episodic, and this is the case for most adolescents.

Many young women do not receive adequate contraceptive instruction until after they have become pregnant for the first time. Even then, professionals dealing with unwed mothers often try to persuade them that they really had not wanted coitus and that it was not going to occur again.³⁵ This makes contraceptive planning less likely and a second pregnancy more likely.

Were it not for the legalization of abortion, the number of births to unmarried teenagers would be going up (from the current 30 per cent pregnancy rate among unmarried sexually active teenagers) rather than remaining relatively steady. About one pregnancy in three is terminated by a voluntary abortion. The decision to terminate a pregnancy reflects both the values of the teenager and her family and the cost of obtaining an abortion.²¹ Abortion rates vary greatly, of course, from state to state.

Social class, ethnic background and religious factors affect rates of both pregnancy and abortion. Adolescents whose parents finished high school or college are more likely to use contraception regularly than those from less educated families.²¹ Young women from low educational backgrounds are more likely to give moral or medical objections to contraception and to perceive their risk of becoming pregnant as less. Regardless of their families' educational background, blacks are somewhat more likely to risk conception and somewhat less likely to use contraception regularly. In general, young women from college-educated families are more willing to seek abortion; they may feel that they have more to lose by an early birth, and certainly they receive more pressure from their families to end the pregnancy.³⁶ As might be expected, religious values figure importantly in both the likelihood of engaging in premarital sexuality and the willingness to terminate a pregnancy should conception occur. Clearly, a physician is well advised to be sensitive to the different attitudes toward sexuality, pregnancy and parenthood held by various classes, and religious and ethnic groups.

There is evidence that giving birth in adolescence, especially in the early teens, often brings a host of adverse social and economic sequelae. In the U.S., about 250,000 unmarried teenage women give birth each year.³⁷ Some eventually marry the fathers, but premarital conception greatly increases the chance of separation and divorce. In a study of 400 adolescent mothers, over half of the marriages that occurred after pregnancy ended within five years.³⁸ Other studies have revealed similar rates.^{39,40}

Early childbearing greatly reduces a woman's chances for continued education and economic independence; a majority of teenage parents may go back

to school, but the demands of marriage and childbearing often force them to drop out again. Therefore, many lack qualifications for stable employment and must seek help from their families or public welfare. More teenage mothers end up on relief than do teenagers who defer childbearing.

About 780,000 teenage premarital pregnancies occurred in 1976. Roughly 530,000 of them ended in abortion or miscarriage, and the remaining 250,000 resulted in illegitimate children. An additional 320,000 pregnancies involved teenagers who were married before or after the birth occurred.³⁷

It has been estimated²⁵ that over 300,000 fewer premarital pregnancies would occur if teenagers who did not want babies used contraception consistently. It also has been estimated that about 700,000 more premarital pregnancies would occur if no contraception were used.

Editor's Note: For an update of statistics relating to teenage pregnancy, the reader is referred to a recent report of the Guttmacher Institute⁴¹ which appeared after this chapter was prepared for publication.

MARITAL SEXUALITY

If we thought that the sociological literature accurately reflected sexual experiences, we might conclude that people's interest in sexuality suddenly declines after marriage. Because sociologists have shown little interest in marital sexual patterns, this discussion is necessarily limited by the paucity of such research.

Historical and Cross-Cultural Patterns. Some scholars believe that the institution of marriage was developed in part to regulate sexual activity in order to control reproduction. Spouses in all cultures are expected to have sexual relations, but there are enormous variations in frequency. In certain cultures, men are ridiculed if they cannot perform coitus nightly; other cultures condone marital coitus only for procreation.

Because sex has been regarded as a strictly private matter in Western society, it is difficult to infer from historical sources whether marital sexual behavior has changed much over time. Nineteenth century books on marriage and medicine reveal a double standard. Men were expected to initiate, and actively seek pleasure in, sexual play; women were encouraged to accept and endure. One medical text written in 1869 said that "there can be no doubt that sexual feeling in the female is, in a majority of cases, in abeyance, and that it requires positive and considerable excitement to be roused at all; and, even if roused (which in many instances it never can be), is very moderate, compared with that of the male."⁴² Similar if sometimes less extreme pronouncements can be found in more recent marriage manuals. However, there is good reason to suspect that, as the expressive and companionable features of marriage have become more central, marital sexuality has become more highly valued and women's potential for sexual enjoyment is more clearly recognized. There is even recent evidence that the Victorian era was not as lacking in accepting female sexuality as we once believed.⁴³

Contemporary Behavior. The view of gender differences in sexual capacity

did not change abruptly. The data from the Kinsey surveys show that marital coitus did not increase among married women born after the turn of the century. On the other hand, coital orgasm did. According to Hunt, the frequency of marital coital activity and orgasm rose somewhat in the late 1960's.³ While the study contains some of the same limitations as Kinsey's in sampling, reliability, validity and other aspects, the evidence assembled seems convincing that several factors—greater openness about sexuality, the encouragement of mutual enjoyment and of emotional exchange, better knowledge of physical sexual functioning—have contributed to more satisfying sexual relations within marriage. In a study of a representative national sample of women aged 15 to 45, there was an increase in marital coital frequency between 1965 and 1970.⁴⁴ About 50 per cent of Kinsey's female sample had tried oral sex; in a survey of 100,000 female readers of *Redbook* magazine,⁴ 90 per cent had done so. Anal intercourse had been tried by over 40 per cent of the *Redbook* sample. Masturbation after marriage was reported by 40 per cent of Kinsey's sample of women and almost 70 per cent of *Redbook's*.^{4,45} Although the *Redbook* study is not comparable to Kinsey's and its sample is not representative of the nation, the sample probably is representative of a large segment of white middle-class females and does indicate some change in the norm. Some conjugal sexual patterns may have changed because today more couples with unsatisfying sexual relations dissolve their union than such couples did in the past. Certainly, people now place greater value on sexual enjoyment in marriage and are more willing to seek information and help when their expectations are not met.

As old problems are solved, new ones are created. To the extent that sexuality becomes an arena for achievement, it may seem like work rather than play,⁴⁶ and expected mutual gratification may place a greater burden on the partners and thus may adversely affect their sexual adjustment and satisfaction. The physician should be equipped to respond to expressions of sexual discontent as couples become more aware of "what they are missing" and more willing to seek advice and aid.

There is some evidence that within long, stable marriages sexual satisfaction fluctuates cyclically rather than declines steadily. More than one study has shown that marital satisfaction drops during the early years of parenthood, reaches a low point when children are teenagers and rises again when they leave home. Being a parent may be rewarding, but it can divert emotion from the conjugal relationship or become a source of conflict affecting the spouses' sexual relations.^{47,48} Despite regrets about the "empty nest," couples have time to reinvest in their marriages, and often the result is increased sexual satisfaction.²²

Sexuality in Middle and Later Life. Coitus becomes less frequent with age for physical and, in many cases, psychosocial reasons. The decrease, however, varies—often in proportion to early-life sexual behavior, especially in men.^{45,49} A study of several hundred older people in North Carolina showed that enjoyment of sexuality when younger was the best predictor of sexual performance in old age.⁵⁰ In addition, those who began sexual activity early

and engaged in sexuality often were more likely to stay sexually active in later life. Since our culture is more encouraging of sexuality for younger people today and since our society is beginning to accept the position that older people can and should be sexually active, more people may be sexually active in later life in the future.

Social Class. It has been believed that the lower social classes have fewer inhibitions and enjoy sexual relations more than the middle class, but empirical data do not agree. Both coital frequency and reported sexual and marital satisfaction are higher in those in the middle-class. This was first reported by Kinsey et al,^{45,49} and then explored in depth with smaller samples by^{48,51}

All of these studies reveal that education and income correlate positively with coital frequency in marriage. College-educated, middle-class couples also vary their sexual activities more; e.g., they engage in extensive foreplay more often, use more coital positions and engage more often in genital manipulation and oral-genital contact.^{45,49} A greater proportion of middle-class women than lower-class women experience orgasm.

In a recent intensive interview study of 50 blue collar-class couples and a comparison group of 25 middle-class couples,⁵² vast disparities in the meanings attributed to sexual behavior in the two class groups were detailed. Blue collar-class wives, far more often than middle-class wives, said that they engaged in coitus merely to comply with their husbands' wishes, felt more constrained about initiating sexual activity and more often felt guilty about performing anything other than traditional sexual practices. Many blue collar-class men resented their wives' traditional approach to sexuality; they complained, for example, that their wives always wanted to do it "the same way." Yet, if the wives expressed too open an interest in sexuality, the husbands tended to see this as a threat to their masculinity. In short, in the blue collar-class there was a war between the sexes in the marriage bed, based in part on very different expectations of appropriate gender role behavior.

There are several possible explanations for these class differences. One is the general influences of education and occupational level on interpersonal behavior.⁵³ It has been argued that people who know more about sexual function may be more skilled in attaining sexual satisfaction. They may be more effective in practicing contraception, thus reducing anxiety about unwanted pregnancy, which often inhibits sexual pleasure. Another possible reason is that insufficient income directly and indirectly strains a marriage. Couples who must divide scarce resources feel resentment over the restrictions imposed on their lives and blame each other for low earnings.⁵² Such strains often make sexual relations an arena for marital struggle.

The degree to which couples share activities may have an effect on sexual enjoyment.⁵³ Lower-class couples with a high degree of communication, task-sharing and mutual interests have more stable and satisfying marriages and sexual interaction.¹⁸ One must hesitate to advance causal arguments, but the same qualities in a marriage that promote communication may also promote sexual adjustment. Lower-class couples who have less interaction generally tend to see sexual relations as a necessary release; those who have more

mutuality are more often inclined to view sexuality as an opportunity to express solidarity. For instance, within the lower class group, rates of orgasm and sexual satisfaction are higher for both sexes in couples who shared household work.¹⁸

Such social class differences complicate the task of a physician who is confronted with patients with sexual and marital dysfunctions. Many lower-class men and women are unaccustomed to discussing their sexual problems with anyone and are not likely to seek a physician's help unless the situation is acute. When they do seek aid, signs of tension relief may be noted merely as a result of open-ended interviews.⁵²

Consequences. Sex is increasingly valued as a form of recreation and intimacy. In contrast to the unmarried, many of whom have unintended and unwanted conceptions, married couples are far more successful than ever before in controlling fertility through contraception, sterilization and abortion. In a national sample of married women,⁴⁴ it was revealed that sterilization was the most common form of contraception (50 per cent) among married couples aged 35 to 44. A disproportionate number of abortions still occur among low-income women, who are less likely to use contraception effectively.⁵⁵ If present educational trends continue, however, we may see greater contraceptive sophistication at all levels of society, thus reducing reliance on abortion. Moreover, recent restrictions on the use of Medicaid funds to pay for abortions can be expected to have an impact on prevalence. Therefore, sexuality may be seen increasingly as separate from reproduction, especially in marriage, a development that will probably influence the nature and quality of sexual relationships.

EXTRAMARITAL SEXUAL RELATIONSHIPS

Historical and Cross-Cultural Background. The double standard pervades sexual relationships, especially extramarital ones, in all societies. The power advantage of males is evident in this phenomenon. Most societies restrict extramarital coitus more than premarital and marital coitus. A cross-cultural survey¹¹ revealed that, although 70 per cent of the cultures studied considered premarital coitus acceptable, only 20 per cent felt that way about extramarital relations. Many cultures that do accept extramarital coitus do not stress lifelong love relationships in marriage. In Western culture, with our emphasis on love and intimacy between husband and wife, sexuality is a part of a relationship that many couples feel is too intimate to share with others. Thus, extramarital coitus is likely to arouse jealousy.

Almost all cultures do prefer that mates get along congenially, but only some feel that the relationship should or must be monogamous or one of deep love and affection. Traditional Eskimo society, for example, allowed for the addition of new partners as situations demanded. If a man's sister-in-law became widowed, he would probably take her as a second wife, giving her a better chance of survival. These practices were compatible with a de-emphasis on exclusive marital ties and with the stress on sharing that aided survival in that culture.⁵⁶

Men often covertly approve of extramarital adventures for themselves and

keep such affairs secret from their wives. Of course, some of their partners are other men's wives, but such a contradiction is not usually acknowledged.^{14,22} Today a small number of married people are trying to work out more open arrangements that allow both spouses opportunities for extramarital coitus.

Most societies feel that extramarital coitus is a greater threat to marriage and the family than is premarital coitus. Although a growing proportion of our adult population accepts premarital coitus (20 per cent in 1963; 50 per cent in 1970; 70 per cent in 1975),²² such radical change has not occurred in attitudes toward extramarital coitus. Less than 30 per cent accept such relationships regardless of the circumstances.

Patterns of extramarital sexual behavior also have been slower to change. Kinsey et al reported that about half of all married men and one-quarter of married women had experienced extramarital coitus at least once by age 40. More recent data from different samples show no increase among men but suggest a rise among women. For example, of women in the *Redbook* study who were born in the 1930's, about 40 per cent had had extramarital coitus.⁴ In another study³ a rise was reported only for wives younger than 25.

Changes in premarital sexual behavior do not automatically bring changes in extramarital behavior. For example, in Sweden, which now generally accepts premarital coitus, attitudes and behaviors about extramarital coitus have not changed as dramatically.⁵⁷

Contemporary Patterns. Extramarital coitus has been the subject of relatively little research since that of Kinsey, although some work has appeared in recent years.^{4,58,59} Extramarital relationships that involve coitus may predominantly express love or pleasure and also may or may not be accepted by the married couple (i.e., consensual or nonconsensual). (We shall not discuss extramarital relationships that have emotional importance but that do not involve sexual activity.)

There are, then, four types of extramarital sexual affairs: (1) love-focused and consensual; (2) pleasure-focused and consensual; (3) love-focused and nonconsensual; (4) pleasure-focused and nonconsensual. The fourth type—pleasure-focused and nonconsensual—is by far most common for men and probably also for women, although not to the same extent. To some degree, our society has a tradition of tolerating covert extramarital coitus by husbands more so than that by wives.

Pleasure-centered and consensual extramarital coitus may be becoming more common. However, acceptance commonly carries the restriction that extramarital love (as opposed to coitus) should be avoided.⁶⁰ Even those with such agreements spare each other details of their affairs. There is a strong desire to keep the extramarital relationship separate from the marriage so as not to upset the marriage relationship.

Such activity sometimes involves "swinging," the exchange of partners. This pattern has recently attracted a great deal of attention.⁶¹⁻⁶³ In "open" swinging, both spouses act with full awareness of details or in view of one another. Usually, men initiate swinging by talking their wives into it. However, some husbands find that they cannot perform as often as they would

like and that their partners are not as attractive as they would like. Also, they may be threatened by wives who discover that they are multiply orgasmic or that they can enjoy sexual relations with women as well as men. Some husbands who talk their wives into swinging later try to talk them out of it.

Love-focused consensual affairs are quite rare. Some occur when the marital relationship, although significant, is far from fully satisfactory. However, some authorities argue that such affairs also occur in very fulfilling marriages and that the affair adds a new dimension rather than compensates for a weakness.⁶⁴

The love-focused and nonconsensual affair is the kind our society has traditionally considered most likely to destroy a marriage. Jealousy can indeed disrupt the marriage if the relationship is discovered. In fact, whenever the extramarital partner becomes the more important one, the marital relationship may be significantly altered. This can happen despite the intention to limit emotional involvement.

Consequences. The mutual effects of marriages and affairs depend in large part on the partners' capacity and desire for intimacy. The traditional romantic view of intimacy is close association, sharing and personal contact in both a physical and an emotional sense whereby one person fills another's needs entirely; obviously some people manage to achieve this, although we do not know how many or how easily. A minority view of intimacy, but a growing one, is the diffuse and partial one. According to this view, one person cannot satisfy all of another's needs for intimacy, and there is room in one's life for several (perhaps almost equally important) sources of support, friendship and sharing on an emotional if not also on a physical level. The diffuse view is held by many people living in communes and by those who espouse group marriage and love-oriented, consensual extramarital affairs.⁶⁴ Some marriage counselors agree that the diffuse view of intimacy is more realistic and that the total view expects too much from a mate, thereby inviting resentment and disillusionment.

Another important factor in the effects of extramarital coitus is one's view of sexuality. In our culture (and many others), women have traditionally associated sex with affection and love; men have associated it primarily with pleasure. These differences, although clearly diminishing, are still significant in determining the consequences of extramarital coitus.

The length of the marriage affected by extramarital coitus is also a determining factor.⁶⁵ It has been reported that extramarital coitus during the first 12 years of marriage is associated with marital unhappiness, but that this is less true after 12 years.⁶⁵ There may be a greater sense of security and a greater tolerance of a mate's private activities in a long-term, stable marriage than in the early years of marriage.

Obviously, there are no simple answers about the outcome of extramarital coitus. The type of extramarital relationship, the type of marriage, the people's views of intimacy and of sexuality and the length of the marriage are only some of the variables. If a patient has problems about extramarital sexuality, the physician should not assume that his own attitude is the same as the

patient's; instead, he should try to clarify the situation in order to determine whether or not marital counseling is desired or indicated.

RELEVANCE OF THE SOCIOLOGICAL PERSPECTIVE FOR PHYSICIANS

Physicians are often called upon to give advice or to play the role of social arbiter in matters concerning sexual behavior and values. Thus, it is important for them to be aware of general trends in the society and of their variations in different ethnic and class groups. By gaining such information, physicians may be able to give a more helpful medical opinion, whatever their private moral position may be.

Some physicians will be tempted to label behavior they deem undesirable as "unhealthy" or "sick." If a sexual practice is likely to disturb physiological function, there is a medical basis for calling it unhealthy. However, whether a sexual practice is seen as unhealthy often depends on one's cultural training. For example, a man raised in Latin America who ejaculates in 20 seconds may not consider himself a premature ejaculator nor may his partner; his culture doesn't teach him to expect his wife to reach orgasm as often as he does. In our society, a middle-class man who reaches orgasm in 20 seconds is more likely to label himself a premature ejaculator; a blue-collar man is somewhat less likely to do so. Clearly, the culture helps define "dysfunction."

The fact that sexual values vary between segments of one society, over historical time and during the course of one person's life does not mean that all standards are equally advantageous for an individual or society. Furthermore, changes that are desirable from one point of view may be undesirable from another. For instance, premarital coitus is usually viewed with more disfavor by parents than by their offspring. Reducing hostility to homosexual behavior may threaten certain social interests but it also promotes the interests of others. Abortion is seen by some as life-saving and by others as life-destroying.

Physicians cannot hope to resolve these moral dilemmas for their patients, but they can at least serve as educators. There is much ignorance and misinformation about sexuality that they can help to dispel. Physicians may feel unqualified to fill this void alone; perhaps some feel that it is the responsibility of the family, church, school or family planning clinic. Nevertheless, the task often does fall to them and, when it does, it gives them a responsibility to be well-informed.

In this chapter, some sociological studies of sex that bear on the physician's clinical decision-making and consulting responsibilities are reviewed. Subject matter is confined to premarital, marital and extramarital heterosexual behavior, which has received most study and which requires most of the physician's clinical attention.

Clinical Aspects

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The sociological data presented in this chapter may appear to the neophyte physician to be interesting and informative, but the information is perceived to be relevant to clinical practice only when the physician starts to experience firsthand the influences of class, religion and ethnicity on the physician-patient relationship and on the management of sexual problems in practice. In addition, the norms of society, which frequently differ in different classes, religions and ethnic groups, affect perhaps even unconsciously the attitudes of physicians as well as of patients. To "bring home" the significance of sociological perspectives to the practicing physician, the following short case illustrations are offered.

Many blacks are sensitive about the widespread myth that blacks are promiscuous:

Case 1: A 32-year-old, attractive, black married woman with two children refused to be interviewed by a white psychiatrist, a member of the research team.⁶⁶ She was reluctant to disclose that she had had premarital intercourse, so convinced was she that this would confirm the white psychiatrist's misperception of blacks and that she would have been labeled and stigmatized as "promiscuous." She had no hesitancy, however, in talking with a black psychiatrist who easily obtained her sexual history.

White women married to blue collar workers can resent the often obligatory nature of sex even if they attain orgasm easily:

Case 2: As one woman married to a member of a construction gang expressed it, "My husband always gives me the feeling that he needs my orgasm for his ego even more than I need it for myself, and I resent it bitterly."

The following case illustrates the effects of religious orthodoxy, but in a paradoxical fashion:

Case 3: A 28-year-old woman, married for two years, asked for help because of an inhibition of sexual desire secondary to an inhibition of excitement. She had a very passionate premarital relationship with her fiancé, but her excitement and desire ceased on the night of her marriage and had been absent since. When asked for an explanation, she replied, "You see, we were brought up to think of sex as dirty, bad and very sinful, particularly by my mother. She would never in a million years believe I would have sex before marriage. Knowing this, I felt free to have it. Now that I am married, she knows that sex is expected. I feel that she is in the bedroom with me watching every move, and I am paralyzed."

The management of sexual problems is often made more difficult by the values of the physician. Here are a few illustrations:

Case 4: A gynecologist referred to another physician a 17-year-old unmarried woman who had recently given birth to a normal infant. The referring physician had delivered the child but, when a few weeks later he was asked for contraceptive assistance by the young woman, he had turned her down saying "I'll be damned if I will assist you in any way in sustaining your promiscuous behavior." At least the physician was caring enough to refer her to another physician who, in his hierarchy of values, felt that a greater level of immorality than premarital coitus was bringing another unwanted child into the world or having an abortion.

Case 5: A middle-aged married woman with three college-age children suffered from moderately severe hypertension for which she had been treated for some years by an eminent internist. The patient was married to a sadistic, paranoid man who, in fits of rage, would strike her, sometimes inflicting painful bruises and black eyes. She had endured this treatment through many years of marriage, but now that the children were away at school, she began an affair with a kind and affectionate long-time friend. She was, however, troubled by guilt, for this extramarital relationship was counter to her religious upbringing and her own norms of conduct. Despite her guilt, she was having, for the first time in her life, intense sexual feelings and a sense of fulfillment that was altogether missing from her marriage. Her conflict and guilt caused her to confess the affair to her internist from whom she expected sympathy and understanding.

Instead, no doubt because of his own moral strictures, he upbraided her severely and concluded by stating that if she did not cease the affair from that moment on, he could no longer continue as her physician. Fortunately she was able to bring her problems to a psychiatrist who gave her the necessary empathy and arranged for a support network of her friends and relatives that sustained her until she could obtain a divorce and marry her friend and lover. Interestingly, her hypertension, which had existed for many years and had required daily medication, dropped to normotensive levels when her daily marital stress was removed.

It is not uncommon for a physician to recommend sexual behavior that is unacceptable to the patient:

Case 6: A gynecologist, without inquiring about his patient's attitude toward masturbation, suggested to a preorgasmic woman that she masturbate at least two to three times a week. Outraged by the suggestion but too embarrassed to voice her objections, she never returned to the gynecologist but instead consulted another to whom she confided that she had been taught that masturbation was a dreadful sin and that its perpetrator was certain to go to hell.

Conflicts in moral outlook between two generations can be seen in this case, which also illustrates how two parents of the same generation may differ:

Case 7: A couple married for 28 years had a history of growing hostility and increasingly frequent arguments over the past five years, behavior that had led them eventually to sleep in separate bedrooms. The major recent cause of their marital conflict was their divergent attitudes toward the lifestyles adopted by their two daughters, aged 23 and

26. Both were living with male friends in short committed relationships, and both had chosen not to marry—at least for the time being. The father did not particularly like this arrangement, but he accepted it. His wife bitterly opposed her daughters' lifestyles to the point where she had broken off any relationship with them. This had been very painful to her husband, who was intensely angry over his wife's intransigence.

Socioeconomic factors also have significant impact. In the world of financial and emotional impoverishment, some young unmarried women who have opted to carry their pregnancies to term refuse to give up their newborn children. With a tremendous yearning for love, but suspicious of men and distrustful of intimacy, they believe that their love for the child will somehow magically make up for all of the deprivations they have suffered. Although by no means restricted to black women, this attitude is more commonly seen among black women than white women. The differences in frequency probably are due to several causes, one of which is the greater chance of emotional deprivation among blacks. Another possible cause is that the history of black women as the center of the household—the *uterine* unit—in a world of male unemployment, even desertion, may predispose to this choice. Differences in expectations regarding education and employment between blacks and whites may also play a role. The unmarried young woman who has to care for an infant is in a precarious position with regard to her future.

There seems to be a significant difference between lower-class and middle-class people in their attitudes towards seeking help for sexual problems. Blue collar workers, white and black, seem reluctant to label themselves as needing help for this aspect of their lives. They hesitate to discuss problems of sexual disinterest or sexual performance. To them it is stigmatizing. The same attitude seems to exist, although to a lesser extent, with regard to seeking help for marital problems. However, a way out for the professional is possible. If the physician senses this reluctance, but suspects a sexual and/or a marital problem, he can ask if there are any significant "family" problems or concerns. Labeled in this way, the blue collar worker or spouse is more likely to accept help. When referring a patient from this social class to a sex therapist, the physician should keep in mind this possible sensitivity.

We have been discussing some of the ways in which sociological perspectives may assist the physician in helping patients with sexual problems. Many additional dimensions might have been included. There are two final ones: (1) A sociological perspective allows a physician to be on firm ground when he responds to a patient's query on whether certain behavior is usual; and (2) awareness of the great range and variation in sexual behavior demonstrated by sociological data increases the physician's acceptance of practices he might otherwise have found to be immoral or aesthetically displeasing.

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